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NATIONAL HOSPITAL PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT:

PITTSBURGH, PENNSYLVANIA

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PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

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1.0 OVERVIEW OF PITTSBURGH, PENNSYLVANIA

The Pittsburgh case study site is defined as the city of Pittsburgh, plus the surrounding communities contained in Allegheny county. This is less than the metropolitan statistical area, which comprises Fayette, Washington, and Westmoreland counties in addition to Pittsburgh. The outlying counties were excluded because Allegheny county itself is large and contains the greater Pittsburgh urban area. In addition, the mountainous character of the region renders communities in these adjacent counties somewhat separate from Pittsburgh. Pittsburgh itself is physically characterized by the famous three rivers: the Allegheny, Ohio, and Monangahela, and the very steep hills surrounding the valleys in which Pittsburgh is located. These natural barriers have created a city of separate and distinct neighborhoods, and these two factors have also fragmented the market for health services to a certain extent.

The population of Pittsburgh itself is 423,938 and Allegheny county is 1,450,085. The city is roughly 75 percent white. Sixteen percent of the population in the city of Pittsburgh is over age 65, and most residents of Pittsburgh are natives, on the order of 80 percent. There are 29 hospitals and 11,352 beds, with 2.7 beds per 1000 population in the city. The county contains 40 hospitals, 15,981 beds, and has 11 beds per 1000 population. The unemployment rate in 1980 was 9.2 percent in the city, with 11.9 per cent of the families below the poverty level.*

The economy of the Pittsburgh area is diverse; the banking and finance, management, education, and health care sectors add balance to the strong industrial base. Because of that diversity, the problems faced by the steel and other heavy industries have not been as devastating for the economy of Pittsburgh as for some other areas. Consequently, local service industries, including health care, have survived and continued to prosper despite the better publicized economic reversals of particular industries in the so-called Rust Belt.

This is not to minimize the importance of the highly unionized blue collar industries to the local health care system. In fact, the style of health care delivery characteristics of the Pittsburgh area is a direct response to the demands of unions for extensive employer-paid, health insurance benefits. Unions fought long and hard to obtain those benefits and, even in a time of economic hardship and retrenchment, are reluctant to give them up.

Another important characteristic of the Pittsburgh area health system is the relatively large share of the health insurance market (estimated at 85 percent) captured by the local Blue Cross plan. Historically, the plan has maintained good relationships with health care providers and with the large employers who are its most important customers. In the past, Blue Cross negotiated contracts with hospitals calling for cost-based (in contrast to charge-based) reimbursement. Paying health insurance premiums based on costs rather than charges appealed to employers; and unions looked favorably upon the freedom

*All the above figures are for 1980 from the County and City Data Book, 1983.

of choice of provider that is characteristic of Blue Cross insurance plans.

This historical relationship between cost-paying insurers, hospitals, employers, and unions helps explain several other characteristics of the local health service system. For one, it partially explains why nontraditional forms of health services delivery, notably HMOs and PPOs, have been slow to take root and flourish in Pittsburgh. Such programs are more often sponsored by commercial insurers and, by design, restrict enrollees' freedom of choice of provider.

There are some signs that this situation is changing. Employers are awakening to the effect of the health insurance benefit on their bottom lines and to the cost containment potential of these nontraditional forms of health service delivery. Further erosion of union strength, and the concomitant rise in importance of service and other white collar industries will likely increase the demand for these alternative delivery systems. To the extent that HMOs, PPOs, and similar systems depend more heavily than traditional systems on case management, utilization review, and related cost control techniques, the Pittsburgh area might be on the brink of an era of change in its health care delivery system.

Thus, Medicare's Prospective Payment System arrived in Pittsburgh at a time when economic forces are just beginning to alter the underlying demand and ability to pay for health care in the region. It is important to keep these concurrent changes in the economic environment in mind when interpreting the causes of changes in the Pittsburgh health care delivery system.

At present, PPS has not had a major impact in the Pittsburgh area. There have been effects, however. Lengths-of-stay have fallen, the growth of the post-hospital care industry has been stimulated, and hospitals have endeavored to improve efficiency. Nonetheless, health care in Pittsburgh is organized and delivered much the same as before the introduction of PPS. This is consistent with findings from other areas of the country in which PPS seems to have largely reinforced trends that were already in place.

The interviews conducted by the site team in the Pittsburgh area allow a snapshot view of Pittsburgh hospitals, HMOs, physicians, post-hospital care, and program operations two years into the Prospective Payment System. It is clear that the effect of PPS at this time is rather small and its major impact is yet to be felt. This is due to two causes: the, as yet, incomplete transition of prospective reimbursement from hospital-specific to national rates, and the transition in the PRO. The former cause will undoubtedly have more of an impact on smaller primary care institutions which are not sheltered by payments for indirect medical education, nor stable, high volumes. The increased experience of the newer PRO, and federal pressures, will also undoubtedly have a significant impact on health services delivery in Pittsburgh.

The Pittsburgh hospital market is dominated by five, large, tertiary care facilities. In addition, there are some specialty hospitals, and then the bulk of the hospitals, which are primary care facilities. The tertiary care facilities are fairly close in size, and although there is an agreed upon ranking of these facilities in Pittsburgh, there is no strongly dominant hospital. Likewise, there seems to be little cooperation in an attempt to avoid competition among these facilities. Service competition is very strong,

and there is some evidence of limited price competition. Advertising exists and is becoming more important. None of the hospitals are expanding capacity, and one has recently reduced its bedsize. There has been, however, a limited expansion in the form of urgent care facilities. This may prove to be more important in the future. There is no evidence that PPS has had any impact on competition in this community.

PPS has caused administrators to intensify management efforts at efficiency, but not to try and "manage" physicians. The hospitals' financial positions have been solidified by PPS. Those which were doing well are doing better, and those which were doing poorly are doing worse.

For now, Medicare's PPS has not had an overwhelming impact on patient management and physician practice patterns in Pittsburgh. Incentives inherent in PPS have helped to lower admissions, increase use of outpatient medical care, and shorten lengths of stay. Problems with the system do exist. Many providers pointed out that the DRG system does not take into account the severity of illness within specific DRGs and this has hurt the hospitals whose distributions of severity within a DRG are different from local or national distributions.

At this point, most Pittsburgh area hospitals are not losing money by caring for Medicare patients. For almost all the hospitals visited, the hospital specific portion of the Medicare payment is well above the national amount. As the national rate's portion of the Medicare payments increases, PPS effects will increase in the Pittsburgh health care system.

The post-hospital care industry is in the midst of a very lively transition, the outcome of which is difficult to predict. Medicare regulations themselves may limit the supply of needed services. Hospitals' entry into this market could reduce competition through (implicit) tying agreements. This remains unclear, but the lack of competition is probably of less concern than a lack of supply of certain services.

The discharge planning process is being strengthened at some hospitals to include additional personnel. The Discharge Planning Committee involves more staff in responsibility for planning. In addition, home care representatives are assisting in decision-making through assessments provided in-hospital. Discharge planning departments are becoming increasingly assertive and now initiate screening and identification of "high-risk" patients.

Program operations generally seem to be adequate. Providers of post-hospital care have quite a few complaints about the fiscal intermediary, but this may be due more to Medicare payment policies than the FI's actions. The newer PRO is not as yet extremely activist, but is likely to become more so as its experience, and federal pressures, increase. In conclusion, PPS has had some impact on Pittsburgh, through decreased lengths-of-stay, increased demand for post-hospital care, and greater cost-consciousness of hospitals, but the changes are relatively small, and may continue to be, even as the transition towards a national payment rate is made.

2.0 SCOPE OF INTERVIEWS

There are 25 non-federal, short-term, general hospitals in Allegheny county; 18, in the city of Pittsburgh. Of these, 5 hospitals participated in the case study. Three of the participating hospitals are very large, with over 400 beds. The other two participants are smaller, in the 200-300 bed range. The participating hospitals include 3 of the 5 major tertiary care facilities for the Pittsburgh area. Thus, although the hospital participation rate was low, it was possible to obtain an accurate impression of the hospital services market in Pittsburgh because most of the major tertiary care facilities and some primary care facilities did participate in the study.

Twenty-four individuals were interviewed in 5 hospitals, 2 physicians outside of hospitals, eight people at HMOs, three people at the peer review organization, one at the fiscal intermediary, 4 in nursing homes, 5 in home health agencies, and 1 in a visiting nurse association. This totals to 50 people interviewed over five days. Table 1 presents the number of interviews by topic area and the positions of the respondents. Of the 50 interviews, 10 focused on hospital competition, 13 on patient management, 15 on aftercare, 4 on program operations, and 8 on alternative health plans.

Hospital chief executive officers were interviewed to gain insights into the overall strategies and competitive positions of their hospitals. The hospitals' questions pertaining to specific pricing behavior and the hospital's financial status. Additional information of the competitive nature of the hospital services market in Pittsburgh was obtained via interviews with HMO directors and other managerial staff about contracting and other competitive strategies.

For utilization and patient management, interviews were arranged with hospital staff, and with physicians. The site team spoke to utilization reviewers, DRG coordinators, and Medical Directors on the hospital staff to obtain information about the hospital's utilization and patient management activities. Physicians were interviewed to determine the impact of these activities. To obtain information about post-hospital care in Pittsburgh, the site team interviewed hospital discharge planners, nursing home administrators, home health agency administrators, and visiting nurse association administrators. In the area of program operations, the director and other administrators of the peer review organization were interviewed to obtain information about the PRO's activities and policies.

TABLE 1

PITTSBURGH, PENNSYLVANIA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations	HMOs
CEOs	5				
CFOs	5				
HMO Directors					1
HMO Medical Director					2
Other HMO Manager					5
U/R Coordinator		5			
DRG Coordinator		1			
Chief of Staff/ Medical Director		5			
Physicians		2			
Discharge Planners			5		
Nursing Home Administrators			4		
Home Health Agency Administrators/VNA			6		
Director of PRO				1	
Other PRO Administrators				2	
Fiscal Intermediary				1	
Total Number of Interviews	10	13	15	4	8

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Introduction

The standard way in which economists analyze competition in markets is via the paradigm of structure, conduct, and performance. Structure describes the basic underlying conditions in the market, such as the number of firms and the size distribution of firms. Conduct is what firms do, e.g., pricing patterns, product offerings, advertising, and inter-firm relationships. Performance is concerned with the effects of conduct on social well-being. Structure is considered to affect conduct which in turn determines performance. This paradigm will prove helpful in organizing the information the site team obtained via our interviews with administrators at hospitals in Pittsburgh.

3.2 Market Structure

Short-term non-federal general hospitals in Pittsburgh can be divided into two broad types: those offering a wide array of tertiary care services as well as primary care services, and those offering principally primary care services.

If a tertiary care facility is defined as offering at least 40 out of the AHA list of 54 services, and offering at least one of three special services: open heart surgery, organ transplants, or burn care, then five out of the 16 hospitals in the city of Pittsburgh are tertiary care facilities. The hospitals in this category are all large, over 400 beds. There is little concentration within this category. The largest share of admissions held by any hospital is 25.5 percent. The share of the other hospitals ranges from 18.1 to 19.0 percent. The size distribution of admissions is remarkably equal for tertiary care facilities. The Herfindahl index, a measure of inequality in sizes, equals .203. It would equal .20 for an equal size distribution. Thus, there is no single hospital which dominates the tertiary care market in size alone. This allows the tertiary care facilities to compete on an equal footing.

The market for primary care hospital services includes the hospitals designated as tertiary care facilities plus all other non-federal short-term general hospitals. For the city of Pittsburgh itself, this amounts to a total of 18 hospitals. The size distribution based on total admissions is less equal here than it was for tertiary care facilities.* Hospitals' shares of admissions range from 0.06 percent to 5.5 percent. Nonetheless, since all the hospitals' shares are small, the Herfindahl index does not indicate much inequality (it equals 0.17; perfect equality among 18 hospitals would yield a value of 0.0556).

As mentioned in the overview, the physical characteristics of Pittsburgh divide the city. The most obvious divisions are caused by the rivers. These divide the city into three parts: North Side, north of

*Using total admissions rather than primary care admissions could be rather misleading, however.

the Ohio and Allegheny river; South Hills, south of the Ohio and Monangahela, and the peninsula between the Allegheny and Monangahela. In addition to the natural barriers, the street system makes travel between some areas difficult, e.g., from Oakland on the south side of the peninsula, to the Highland district on the north side of the peninsula. Therefore, while the market for tertiary care services includes all of Pittsburgh, the relevant markets for primary care services are smaller than the area of the entire city.

The Medicare ratio for the hospitals varied from 38 percent to 68 percent, with a mean of 50 percent. With a ratio of 67.7 Medicare admissions for every thousand in Allegheny county, the Medicare ratio for hospitals is expectedly high. Medicaid made up a much smaller proportion of admissions, ranging from 3 percent to 17 percent, with a mean of 11 percent. The major third-party payer in Pittsburgh is Blue Cross. The share held by Blue Cross in the respondent hospitals is approximately 25 percent, with very little variation across institutions. Pennsylvania does not have a county hospital system, thus no single hospital has an extremely high proportion of free care.

The large tertiary care facilities received significant payments for indirect medical education, on the order of 9 or 10 percent. The primary care facilities interviewed received no such payments, although one of them did receive about 5 percent outlier payments. That same hospital also received disproportionate share payments. All of the hospitals' hospital specific amounts exceeded the national amount by a significant sum. The difference ranged from $300 to $900. Although occupancy rates throughout the region were down, the tertiary care facilities interviewed all had very high occupancy rates, on the order of 90 percent, due to rising admissions. The experience of the primary care hospitals interviewed was just the opposite: occupancy rates had fallen; in large part due to falling admissions.

3.3 Conduct

Since the focus of this report is the effect of PPS on hospital care, areas of hospital conduct with respect to PPS shall be examined. These areas are: relationships with physicians, internal management, non-price competition, and price competition.

3.3.1 Relationships With Physicians

Since PPS pays hospitals a fixed rate per DRG, hospitals have an incentive to cut the costs of producing treatment for any given DRG. One important way to do this is by managing physicians. Consequently, the case study discussions with hospital administrators focused somewhat on this area.

All the hospitals report that they held extensive educational programs for physicians following the onset of PPS. These programs indicated the workings of PPS and the requirements of the system for physicians. In addition, one hospital educated physicians about the importance of holding down length-of-stay for the hospital's finances.

All of the hospital administrators except one receive DRG reports on individual physicians. Only two of the administrators disseminate the results of these reports to physicians. The rest do not do so systematically. At least one administrator feels that DRGs do not accurately reflect costs, and thus the hospital does not utilize DRGs for management purposes.

Two other areas in which at least one hospital reports PPS having an effect are contracts with hospital-based physicians and the appointment of a medical director. Three of the five hospitals indicate that they have switched some hospital-based physicians (either anesthesiologists or radiologists) from contracts to fee-for-service. Hospital-based physicians' salaries are covered under Part A of Medicare, but switching physicians to fee-for-service shifts the financial responsibility for their payment from hospitals to Part B of Medicare (for Medicare patients). Two of the hospitals have recently appointed a physician to the administrative staff to facilitate dealings between physicians and the administration. Both respondents indicate that this is due to the increased importance of hospital-physician relationships under PPS.

This does not seem to be the area of highest importance to administrators in trying to cut costs. Hospitals are applying few constraints to physicians, and are not supplying them with information on how their actions affect the hospital financially. Instead, administrators are focussing their attention on cutting costs through internal management. Undoubtedly, this is because this is an area directly under their control and because most of the hospitals are doing better financially under PPS than they had under cost-based reimbursement. The financial incentive to put pressure on doctors does not exist at this time.

3.3.2 Internal Management

Another incentive provided by the PPS fixed payment is to cut overhead and operating costs through management procedures. All the hospital respondents agree that this is an important way to cut costs, and that PPS has provided them with an incentive to do so, although other incentives to be conscious of costs had existed before PPS. One of the respondents feels that the PPS incentives to be efficient work indirectly, through the increased competition engendered by the system, rather than directly from the payment system itself.

Of all the ways in which hospitals might control costs in response to PPS, this area received the most emphasis by administrators in Pittsburgh. Hospital administrators are managers and thus are most inclined to work on improving management as a method of cost control. In addition, an administrator who is going to ask for changes in physician behavior to control costs is in a much stronger position if his or her own "house is in order."

The case study uncovered a number of management activities that hospitals have undertaken in an effort to control costs. All the hospitals have introduced some new, improved form of inventory or

materials management. Typically this involves some form of computerized system. None of the hospitals have done anything significant to change management of the operating rooms, however. One hospital has instituted some small changes in the operating room and another is reviewing the matter, but operating room schedules have remained essentially unchanged from the standard weekday schedule. This still leaves hospitals with operating rooms unused at hours unpopular with physicians.

The hospitals vary in their policies toward labor. The large, tertiary care facilities, which are doing well financially, have instituted minimal policies. None of these hospitals have resorted to layoffs or cut wages. One is emphasizing productivity, one is offering the option of early retirement, and one is recruiting. The smaller, primary care institutions, however, are cutting back. Both are reducing staff and one has converted some full-time positions to part-time positions.

All of the hospitals are now engaged in more careful, sophisticated budgeting processes. This involves more precise cost accounting systems and special studies of the cost of various services, and cost-benefit analysis of prospective undertakings.

All the hospitals indicate that they have invested in cost-saving capital equipment in recent years, but all but one indicates that this investment had occurred prior to PPS. All of the hospitals are also engaged in group buying arrangements. The two that had not had such arrangements prior to PPS had joined a group purchasing agreement in the recent past. The respondents agree that PPS provides an incentive for being a member of a group buying agreement.

Although all the hospitals have continued to invest, the investments are for equipment or facility renovation, rather than capacity expansion. In fact, one of the tertiary care facilities has recently cut its number of beds, reducing capacity. This seems to be a response to the uncertain and competitive future, in a community with a substantial number of beds.

All of the hospitals are involved in service sharing with other hospitals. The shared services are embodied in pieces of expensive capital equipment. For the tertiary care facilities, the shared services are lithotripsy, magnetic resonance imaging, and a trauma unit helicopter.

All of the respondents indicate that they have taken measures to improve the efficiency of management itself. Some extensive reorganizations have occurred, including, in one case, the turnover of nearly an entire administration. There is clearly an emphasis on aggressive, efficient management, and the hospitals have made this their first priority in responding to PPS.

3.3.3 Non-Price Competition

Hospital conduct in the area of non-price competition is defined as any rivalrous behavior, excluding price adjustments. This category includes service offerings, amenities, advertising, and location.

The tertiary care facilities all offer a complete range of services. Hospitals that do not have a burn care unit are not planning

on offering the service. In the cases of other services, however, if one of these facilities does not have a service offered by another facility, it is planning to offer that service. Although all the hospitals recognize the advantages of being the first institution to offer a service, all of the tertiary care facilities indicate their intent to offer a service for which another hospital was the "first-in." The primary care facilities recognize the advantages another hospital possesses in offering a service first, and do not indicate any intentions of offering a service when another hospital was first-in. Each of the primary care hospitals offers a form of subacute care as their flagship specialty service.

As far as the tertiary care institutions go, there is direct and active competition over service offerings. There do not seem to be any tacit agreements to specialize, except in the case of burn care. There is even some service competition with the very specialized, well established institutions (e.g., OB/GYN, Pediatrics) in Pittsburgh. The primary care institutions, however, do specialize in a small number of services, typically those which emphasize subacute care.

All of the large tertiary care facilities have both extended their use of cost-benefit analysis of potential service offerings and intensified the analysis itself. None of the hospitals indicate that PPS has depressed their adoption of new technologies. One chief executive officer indicates that he feels that the end of Medicare's pass-through for hospital capital expenses will have no effect on his hospital. The same individual feels that the end of the pass-through would have an adverse effect on biomedical research and development due to most other hospitals' depressed demand for new technologies.

All of the case study hospitals use advertising in some form, except one. This hospital, a smaller primary care facility, is not actively engaged in promotional activities. The other hospitals are using mainly radio and the print media to disseminate their messages. Television is not currently used to any great degree but the large tertiary care institutions are planning to employ it. One of these institutions has engaged a marketing firm to help plan the promotional activities. All of the hospitals are very concerned with amenities and patient relations and are engaging in steps to improve amenities such as room decor and patient relations.

One other form of non-price competition is location. One of the large tertiary care facilities has opened an urgent care facility in the suburbs, and has plans to open another such facility. These locations provide referrals to the hospital and establish a means of tapping new demand. They also may provide some pre-emptive deterrence of entry by rivals in those locations. Of the 18 hospitals in Pittsburgh, three have associated facilities elsewhere in the Pittsburgh MSA. Only two are associated with national, multihospital systems.

3.3.4 Price Competition

Although most analysts of the hospital industry contend that little competition occurs over price, due to the extensive third-party coverage

of hospital expenses, the case study did explore hospitals' pricing policies with hospital administrators. Since many analysts feel that HMOs are a means of engendering price sensitivity in hospitals, the interviews also asked about contracts with HMOs.

While all of the administrators feel that patients are not price sensitive, they all feel it is important not to be too far out of line with similar institutions. One respondent says that cutting prices will not increase business, but raising prices will hurt. Thus, rather than attempting to attract patients with lower prices, hospital administrators try to avoid losing business from prices elevated above those of rivals. Nonetheless, two of the hospitals report pursuing price cutting as a strategy. In one case, the strategy is felt to be successful, because the price cuts occurred after rivals' budgets had been set, and thus price adjustments were not possible. In another case, the strategy was felt to be unsuccessful, because rivals cut prices simultaneously and independently, cancelling out any potential volume gains due to the price cut. None of the other hospitals indicate that they have pursued any aggressive pricing strategies. All are aware of other hospitals' prices.

None of the respondents indicate that they currently have any significant business with HMOs. Four out of five respondents have at least one contract with an HMO. One respondent indicates they give a discount of 25 percent for the HMO contract. Another hospital contracts with its own HMO. A third hospital is developing its own HMO. One hospital said that it was difficult to get HMO business unless the HMOs considered the hospital desirable. All the respondents consider HMOs a growing part of the Pittsburgh health care market and an important force in the near future.

Thus, at this time, there appears to be some very limited price competition, due in part to price-cutting, and in part to HMOs. Price competition should increase as the market share of HMOs increases.

3.4 Performance

In this section, the direct effects* of the PPS reimbursement method and indirect effects through altered hospital conduct, as described in Section 3.3, are considered. The interviews with hospital chief executive and chief financial officers included questions about the effect of PPS on: profits, length-of-stay, admissions, outcomes, inpatient-outpatient substitution, technology adoption, and horizontal and vertical integration.

The profit position of the participating Pittsburgh hospitals was amplified by PPS. Those hospitals that were doing well before PPS report they are doing even better. Those doing poorly, report doing even worse. All of the hospitals' hospital specific amounts exceed the regional and national federal amounts and the hospital administrators realize that their profits will fall as they move on to the fully

*Standard economic measures of performance are measures or indicators of social welfare. We do not employ those measures here. Rather, we consider the outcomes due to conduct and PPS.

national rate. The three large tertiary care institutions all receive payments for indirect medical education. An administrator at one of these hospitals says that profits are due in no small part to these payments. In addition, admissions at the tertiary care institutions have been rising. All of these hospitals have Medicare patients as a large portion of their total discharges.

The two primary care institutions have had very different experiences. One hospital had been doing well before PPS and the other had been doing poorly. The hospital that was doing well is in an area with a stable, middle-income population. When PPS was introduced, the administration was able to cut costs and make a profit under the system, without the aid of payments for indirect medical education, outliers, or disproportionate share. It is not clear if these profits will remain with the fully national rate. The other primary care institution, with roughly the same number of beds, had been in financial difficulty for many years before PPS. The neighborhood in which the hospital is located has been in decline for some time, and other hospitals with more prestigious reputations are located relatively close by. This hospital is doing worse financially under PPS because they have not been able to cut their costs enough to overcome the disadvantage of being a smaller than average hospital with higher than average costs due to diseconomies of scale.

Lengths-of-stay have fallen at every participating hospital. The typical pattern is that lengths-of-stay had fallen immediately following the introduction of PPS, but the rate of decline has reached a plateau. The Medicare average length-of-stay, averaged across the hospitals studied, is roughly 9.5. The average for the non-Medicare population is approximately 6.5. All of the hospitals have experienced falling patient-days. The three tertiary care facilities have rising admissions, in the vicinity of 4 percent per year. The two primary care hospitals have experienced consistently falling admissions.

All of the hospitals have undergone extensive shifting from inpatient to outpatient utilization. The Medicare case mix index has risen for all the hospitals as well. One hospital reports an increase from 1.55 to 1.7 over a 3-year period. Another reports an increase from 1.20 to 1.42. All of the respondents feel that the increase in the casemix index is due to increasing acuity among inpatients admitted. This is seen as a direct consequence of the shift of the less-ill patients from inpatient to outpatient care.

There is not very much activity towards horizontal or vertical mergers or acquisitions among the Pittsburgh hospitals interviewed. One of the tertiary care facilities owns its own home health agency and has acquired a community hospital that will be converted to an exempt unit. Two other hospitals own (at least in part) their own home health agencies. Only one of the hospitals has joined a network, and that is a very recent action. The likelihood of a merger between any of the tertiary care facilities seems remote, and there is no evidence of any potential mergers between any tertiary and primary care facilities.

Of the facilities enjoying profits, there is no activity to expand capacity. One hospital has actually retired a number of beds very recently. Rather, profits are being spent on the acquisition of new technologies,

equipment replacement, facility renovation (e.g., room redecoration, parking garage construction), and management information systems. None of the hospitals feel that PPS had kept them from acquiring needed new technologies.

3.5 Reactions to PPS

The hospital administrators interviewed had a number of interesting reactions to PPS. Following are some of these reactions, in their own words, organized by topic area.

General

"Questionable if the hospitals will be able to survive."

"A small urban hospital is at greatest disadvantage in that it still needs to compete with other urban hospitals. It has to offer same level of services, but it doesn't have the base to carry the fixed cost associated with that."

"May see them dropping out or being absorbed (and maybe closed) in future."

"Government is welching now, they achieved what they anticipated and now they want more."

"Give it to you on one hand and take it away from with the other."

"The main issue Medicare should be focussing on is excess capacity."

"Hospitals need more time to react to decisions. Pursue competition model-good, let organizations go at it. Concerned about: graduate education; capital; update-should be tied to an index, even CPI. Fear is not going to get enough beds closed in a timely manner."

"Some of the objectives of government in terms of checking cost of health care weren't realized."

"Never gave system chance to work-always changing things. Never same from 1 year to next."

"The alternatives were not well thought through. Have compounded difficulties."

"Small hospitals have revenue problems. There is not much left to cut, and low updates compounded over several years become a serious problem. Tough to shift costs to private pay. Percent of private pay patients has fallen, plus private insurors have gotten tougher."

"Things have been too fast."

"There is a sense of arbitrariness about prospective payment."

"The government doesn't understand hospital costs any better than hospitals."

"Government hasn't helped us define quality."

"Emphasis is simply on cost reductions, on money reduction."

"Arbitrariness of cost-cutting."

"Care of poor is a real issue, which is not an issue in the amends of the PPS designers."

"I don't think the government really cares about quality."

"There wasn't enough public education. It was all left to hospitals and MDs. Pitted hospitals and does against each other, but also gave opportunities to work together. Onus of education has fallen on hospitals. Schizophrenic - 'competitive' model, but highly regulated. Government should get off fence."

"Are they going to let us fight it out, or regulate us into oblivion."

Physician Incentives

"No incentive or penalty for MDs directly, and that's a problem."

"Puts only hospital at risk. Doesn't penalize MDs for inefficient care."

On Alternative Health Plans

"Madness of alternative delivery systems structure. As people started experiencing capacity and have reached out for alternative delivery systems, just compound problems. No evidence that AHPs are more efficient. Also, outpatient being pushed-more costly, already have inpatient system in place and can't successfully transfer inpatient to outpatient. Ends up costing the same or more."

Positive Aspects

"Forced hospitals to take a more deliberate financial outlook."

"Will force closings in an overbedded county."

"Will shake out low-quality."

"It's a long range effort to force marginal hospitals out of business and reduce the excess beds in the country."

"Industry-wide, it makes sense."

"Cost reimbursed system leads to financial excess."

"It created competition."

"It created an at-risk environment."

"I think that infusion of risk has awakened everybody to the necessity of behaving in a rational economic fashion and understanding the market place, understanding what the needs are and responding to them."

"I'd have come up with this system, but included capital sooner and let system work and mess around with it."

"It brought some reason into the whole thing instead of the blank check approach."

"Those who were unable or unwilling to deal with it on a rational basis did everything within their power to manipulate the system and we started seeing departures from sound principles."

"Orientation to more disciplined resource use is better."

"It's really forced hospitals to look at themselves as business organizations. Forced to look at: competition, productivity, long-term survival strategies, management, marketing, strategic planning, and advertising. Changed focus of hospital administrator from caretaker to being active manager, entrepreneur.

"I think it's been very positive overall."

"Forces management into a planning mode. Must think about future and make planned choices. Long range planning has been an asset."

"Looked at financial data and seen that current cost accounting is inadequate."

"Helped us to try and understand what costs are."

"Helped physicians and administrators to work more as a team."

4.0 EFFECTS OF THE PPS ON ALTERNATIVE HEALTH PLANS

4.1 Structure of the Industry

Pittsburgh presents a market ready for further alternative plan development--the HMO market penetration is low and there are several Fortune 500 companies and large employer groups. Previous poor economic conditions discouraged HMO growth. But with the city's resurgence, alternative health plans can hope to benefit from the increasing diversification of the economic base. HMO sponsors, too, have recognized Pittsburgh's potential: of the five HMOs, three have been in operation less than two years and have yet to prove their long-term viability, while two have been sold within the past six months to national companies.

Despite several recent new initiatives, health maintenance organizations (HMOs) remain a minor force (less than 10%) in the Pittsburgh health care market. In large part, the slow HMO development is likely due to the high degree of unionization of the predominantly blue collar workforce and their selection of Blue Cross as their insurer. With this traditional source of support, Blue Cross grew to have an extraordinarily high (85 percent) market share.

The market is dominated by one HMO that is part of a national chain, with over 70 percent of the HMO market share. The remaining thirty percent is divided among a brand new medical society sponsored independent practice association (IPA), a small, non-profit locally based group model, an IPA sponsored by Blue Cross/Blue Shield, and an IPA owned by a national insurance company. The number of IPAs is consistent with national trends in this form of HMOs rather than other models to compete with indemnity insurance. The popularity of IPAs reflects general resistance to managed care, making it a difficult market to break into, both in terms of physician participation and subscriber enrollment. Three of the IPA plans are owned by for profit companies, two of which are chains. The third, recently acquired by a large insurance company, is hoping to have a triple option available to its customers. As part of its larger growth plan, the parent corporation is willing to underwrite the current losses of this HMO.

Though originally a local plan, the Medical Society IPA has since sold one quarter of its ownership to one of the largest for-profit HMO companies in the U.S. The plan has enrolled one thousand physicians (asking each to invest a minimum of $1000) and hopes to represent a local physicians' response to the rapidly growing HMO market. Some concern was expressed about the long-term intentions of the company since two of their IPAs have gone bankrupt in South Carolina and Texas.

One of the oldest HMOs in the Pittsburgh area grew out of four health centers operated to service the United Mine Workers. Since its opening (1980), the plan has expanded its membership and physician base, evolving from being strictly based at the clinic sites to a broader group model HMO, with the participation of several other physician groups. It presently offers members care at its traditional clinic sites or through its network of participating physicians. Recently, the plan restructured its ownership, retaining its non-profit status but merging with two other

HMOs (located in Syracuse and Buffalo, New York). This move improved their capital financing yet retained local control through its management contract with the parent corporation.

The largest and oldest HMO in Pittsburgh began ten years ago as a non-profit group practice model, affiliated with a major teaching hospital and enjoying the hospital's union support. Since its inception, the plan has changed its ownership status to for-profit and grown to include seven key centers of service provision. Recently, it opened its model up to include several small group practices. The majority of its members use one of the seven centers.

The site visit included interviews with three HMOs: the largest, for-profit national concern; the small non-profit plan; and the for-profit IPA recently acquired by a national insurance company. The HMOs varied considerably in their organization and service offerings, but have several common characteristics that seem to typify the current HMO market in Pittsburgh. These commonalities and differences between the plans will be described in the following sections.

4.2 Competition

All plans see Blue Cross indemnity insurance as their major competitor. With its exceptionally large market share and relatively innovative programs, Blue Cross of Western Pennsylvania has been able to thwart most of the serious competition to its market share. In addition, the largest HMO (with 85,000 members) represents formidable competition for the smaller plans and new entrants into the market. The Blue Cross and Medical Society IPA plans have been moderately successful at enlisting physicians. One HMO mentioned the Blue Cross and Medical Society HMOs as major rivals, reflecting more its own inability to recruit physicians rather than the actual market shares either of these plans have. Because HMOs are looking primarily towards indemnity insurance to expand their market shares, the HMOs have had to be fairly accommodating in their policies in order to attract and maintain a physician base and subscribers.

In terms of competing for enrollees, the largest HMO stated simply that their strategy has been to enlist the best hospitals and physicians. All plans mentioned that they do not compete on the basis of price but rather the quality of physicians and hospitals they contract with. While this strategy has resulted in high costs (it is the most expensive HMO), consumers have responded to this non-price competition. Other plans vying for increased market share emphasize different strengths. The small non-profit plan emphasizes its small size, local control, and employee commitment to the plan in its presentation to potential enrollees. The IPA owned by the insurance company emphasizes its link to the insurer, relying on a comparison of indemnity coverage to attract members rather than a comparison with other HMOs. This interviewee admitted they had no real advantage over other HMOs in gaining membership.

Undermining price competition in the HMO market is the state regulation that limits the premiums insurers can charge. The Insurance

Commission sets the premiums HMOs can charge their groups. Some flexibility is available to the HMO through adjustments made within tiers of subscribers, but basically HMOs have not been able to compete effectively through price given their uniform community rating. (This community rating is also required of Federally qualified HMOs.) Living within these ceilings, there has been considerable movement among plans to offer high and low cost options in an effort to tailor plans to individual needs. These options include varying co-payments and riders covering drugs, vision care, dental care, and durable medical equipment. They intend to lower basic premium costs and make policies available to small employer groups that generally can not afford rich benefit packages. All the HMOs have future expansion plans into the small and medium sized employer groups. To date, the changes in ownership have not affected their benefit availability, but have in some cases increased the co-payments associated with drug and outpatient mental health services.

4.3 Contracting with Hospitals

Consistent with the small size of the HMO market is the lack of certain practices evident in larger HMO markets. For example, for years many HMOs in Pittsburgh did not independently negotiate rates with hospitals (either discounted charges or per diem rates) but rather chose a lower risk (and higher cost) option--they paid Blue Cross (BC) an administrative fee to obtain their Blue Cross discount (a per diem). This administrative role represents a successful attempt by Blue Cross to assert itself in a market it could not control. By setting an important component of HMO costs (their hospital costs), Blue Cross limited the ability of HMOs to price compete and take away valuable market share. One interviewee said that when the HMO started back in 1980 direct contracts with hospitals were unheard of and the providers would not even consider talking with them. The plans did not secure contracts from hospitals, and, in some cases did not limit hospitalization to certain facilities. Physicians simply admitted to the hospitals where they had privileges and the HMO paid the Blue Cross per diem rate. Because two of the three plans had health centers, most of the admissions went to three or four hospitals, with referrals to the specialty hospitals.

This practice had two important consequences for the HMOs. First, a couple of the plans (the ones located in more urban settings and using more expensive hospitals) had very costly hospitalizations since they made no real attempt to streamline admissions to certain (low cost) providers. Second, the reliance on Blue Cross prices meant the plans had a very difficult time expanding their market shares at the expense of the dominant (price setting) competitor. Currently, HMOs have been breaking away from the Blue Cross relationship, independently negotiating with hospitals for better rates than the Blue Cross per diem. This shift allows HMOs to secure contracts with hospitals that include discounts exceeding those granted to Blue Cross. Plans hope to woo traditionally insured subscribers away from Blue Cross by offering a generous benefit package with high quality providers. It can afford this in part due to

the discounts obtained from hospitals. In addition, as plans grow they improve their negotiating position vis a vis hospitals, enabling them to secure these large discounts.

Not surprisingly, the largest HMO has led the way in both the number of contracts and the discounts it has secured. The largest HMO recently completed its first set of price negotiation with about ten providers, significantly undercutting the effective discount Blue Cross receives in its per diem rates. Currently, eighty percent of the hospitals it uses are under a contract with discounts that exceed those of Blue Cross. In some of the hospitals, the interviewee thought their rates were close to marginal costs. The remaining 20 percent of the hospitals are therefore relatively costly. Physicians at this plan are encouraged to use low cost hospitals, and administrators at the health centers are careful about patient placement in hospitals. No triaging, however, is done.

Other HMOs have been slower and less successful at obtaining favorable contracts. Due to its location, the small non-profit HMO already uses mainly four outlying lower cost hospitals and therefore feels less pressure to obtain higher discounts. It is actively pursuing its own contracts at the expensive inner city specialty hospitals. This plan is also engaged in discussions with at least one hospital for a capitated rate.

The third HMO (the smallest) has had difficulty in securing contracts with hospitals at rates that were equal to the Blue Cross discount. Basically, their small market share undermines their negotiating power. In examining their costs per day, the Plan has recognized the need to secure contracts at all the facilities it refers to, for all services. To date, however, it has been unable to do so given its small size.

4.4 Contracting with Physicians

All of the HMOs in Pittsburgh are IPAs or group models with an IPA component. As network models, these plans have greater growth potential than staff models and allow group models to expand their membership by including small physician groups. Two of the Plans started as group models and then subsequently developed an IPA branch, presumably to compete more effectively with traditional insurance and the Blue Cross and Medical Society IPAs for increased market share. That even the group models have felt the need to develop "physician network" alternatives is a telling sign of the condition of the HMO market. Consistent with the lag in obtaining hospital discounts, the plans have been slow to adopt strict cost containment measures like all-inclusive capitation rates and exclusive use of contracting physicians. As a result, some of the HMOs have not been able to obtain contracts with providers that undercut the Blue Shield usual and customary charges, again making it difficult for them to price compete with the largest insurer in the area. For example, two of the HMOs failed to lock subscribers into contracting providers, resulting in cost overruns for specialty consults and hospitalizations.

For the most part, HMOs are just beginning to break out of their role of accepting prices of physicians without negotiation. HMOs with adequate market share are able to dictate prices to specialists but small plans are stuck with very little negotiating power. Plans have better control over their payments for primary physicians. One plan pays them on a per capita basis, with 20 percent withheld until year end and contingent upon "appropriate" utilization. Another plan put their group practices at risk (20 percent withheld) for specialty, ancillary, and hospital services--clearly having the best control of any visited plan over utilization and costs. In this plan, because of its outlying location, physicians are forced to accept prices assigned by the HMO (usually discounted charges). They either accept the plan's rates or they do not participate. The third plan salaries their primary physicians at the health centers and pays them bonuses for low utilization at the end of the year. In the IPA arm of the plan physicians are paid a capitated rate, with income retained and paid back if utilization is low. Apparently some of the plans had looser arrangements with primary care physicians until liability insurance rates forced plans to secure contracts with their physicians. Also, plans want to be able to use physician names in marketing the plan to other physicians so more emphasis has been placed on formal participation. In an attempt to secure high physician participation, the Medical Society IPA will pay physicians for each service provided based on a survey of local physician charges. They are emphasizing the lack of capitated rates in their marketing to physicians.

The plans vary considerably in their performance review of physician practices, in large part directly correlated with their market share and financial security. The small, for profit IPA has had difficulty in getting physician participation and therefore does not review the contracts it has but rather simply renews them. Conversely, the largest HMO uses the medical director at each site to review and renew physician contracts. However, since all HMOs are fighting for market share and must compete with two IPAs with wide physician participation, the remaining plans have little negotiating power over their participating physicians.

4.5 Utilization Review

The HMOs vary considerably in their utilization controls. Surprisingly, the largest HMO does not have the tightest or most formal UR program, although it does use a variety of productivity measures to assess physician and health center efficiency. It relies on the medical director at each center to authorize all hospitalizations and referrals to specialists. This director is also directly responsible for the medical necessity and appropriateness of all care delivered at the center.

Two of the HMOs have formal UR programs. At their main hospitals, this includes concurrent review of admissions. At the more remote and lower volume hospitals, the HMOs work informally with the UR coordinators. Circumspect care is discussed with the attending physician

and, if necessary, the physician advisor for the plan. All hospitalizations are reviewed retrospectively and can result in the denial of unnecessary days.

All plans required pre-authorization for non-emergency hospitalizations. Another similarity in the plans is the lack of formal application of PRO guidelines. In general, these are perceived as too lenient and would not assist in controlling their utilization since their lengths of stay are below those indicated. None of the plans use written protocols either, relying on individual physician judgement to determine necessity or appropriate levels of care. One interviewee thought that the protocols they could get consensus on were so broad as to be meaningless in terms of any actual application. Inappropriate care is handled in a delicate fashion - the attending physician is either written or talked to privately, but no financial risk is borne by any individual physician.

Some of the plans have performed some analyses of utilization, most often using general measures like hospitals days, mortality rates, and length of stay by physician. No plan uses DRGs to compare either physician or hospital performance. One medical director thinks DRGs are "crummy boxes" and they needed tighter case management than DRGs allowed. Another HMO is just beginning to study physician practice patterns, including referral rates, length of stay by diagnosis, ambulatory encounters, and procedures performed. However, one financial director is convinced that the real leverage is not in UR but in hospital contracting. However, his HMO is more concerned about enrollees than cost control since its membership is well below its break even point. Interestingly, it is also this HMO that continues to need to educate their physicians about referring patients inside the network, clearly indicating a breakdown of the most basic of HMO principles.

4.6 Medicare Enrollment

In general, the HMOs in this site are not pursuing the Medicare population as a potential growth area. The exception is the small non-profit plan which offers an over 65 plan. Basically, there is significant reluctance to get involved with the federal government, particularly with other sectors of the market so underdeveloped.

Because the Medicare enrollment in HMOs has been very low, the impact of PPS has been minimal. Many of the plans report lower use rates and stricter protocols than currently used by the local PRO, so that even these indirect affects on utilization have been nonexistent. Thus, for example, the HMO with a senior care plan was glad to have switched from a cost to a risk contract, claiming that this gave them more flexibility in implementing its own cost controls. Furthermore, this plan is fighting PRO review, arguing its own quality assurance was more effective. Two of the HMOs have been using its own tools for managing utilization well before PPS was implemented, while the third HMO is more concerned with enrolling members than controlling its utilization. DRGs are not used by any of the HMOs as a management or reporting tool.

Many of the plans' over 65 enrollees are age-ins. All the plans felt that Medicare enrollees are very risky, particularly in the first six months while the subscriber got used to the HMO style of care and the inherent restrictions. Because of the higher risk, some HMOs will not enroll over 65 age-in subscribers for six months, while utilization profiles for the entire group are developed. Even then, the high use ratio and often misunderstood restrictions make the over 65 population a market to avoid. As a further disincentive, some HMOs are concerned that if they began to offer a Medicare wrap around package that they would be subject to adverse selection undermining any financial viability. Finally, all administrators are confident that the AAPCC will be reduced in the future and, with the greater risk associated with the elderly, will be inadequate to cover its costs.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Patterns of Medical Practice

Interviewees suggest that several changes have occurred post-PPS in the patterns of medical practice in Pittsburgh hospitals. Generally speaking, hospitals have fewer unnecessary admissions, greater use of outpatient facilities and shorter lengths of stay (LOS). Almost all hospitals except the large tertiary care facilities have seen a decline in admissions post-PPS as well as an increase in the severity of illness in those being admitted. Part of the explanation for this change in admissions is the rise in outpatient care. Improvements in technology have made possible outpatient diagnostic and surgical services that in the past were principally done on an inpatient basis. The "less sick" patients are being siphoned to outpatient facilities, fewer are hospitalized, and those who are hospitalized are sicker. Another part of the explanation of declining admissions lies in increased efforts to substantiate diagnoses at the time of admission, which lead to fewer unnecessary admissions.

Besides promoting declining admissions and greater use of outpatient facilities, all respondents find PPS to be the driving force behind shorter lengths of stay. Post-PPS medical care has been, in a sense, "speeded-up." Patients are now being discharged sooner and it is this practice of earlier discharges, together with admitting surgery patients on the day of surgery, which has led to the decline in average length of stay. Most health care providers do not feel the earlier discharges have meant a decline in the quality of care given. Physicians have learned that patients can be sent home at an earlier stage of convalescence with no adverse effect on patient outcome.

This is especially true of surgical patients. For medical patients, however, this may not be true. Many providers express concern over the availability of home care for patients discharged early. Whether home care is available to a patient is often taken into account in the discharge decision.

5.2 Utilization Review

Utilization review has played an important role in bringing about these changes in medical practice, even though none of the health care providers interviewed see it as being restrictive of most providers' practice routines. All hospitals report having some type of utilization review procedures prior to the advent of PPS. The difference post-PPS seems to be more psychological than procedural for most hospitals; reviews are perhaps done with more intensity now. Stronger utilization review means physicians examine more closely the necessity of each admission and while no hospital places strong, overt pressures on physicians vis a vis admission and discharge decisions, utilization review has had effects.

Typical utilization reviews begin within 24 hours of the time of admission. Some hospitals require pre-authorization of elective admissions. Nurse reviewers assess admission appropriateness using Interqual criteria. Interqual is an algorithm developed by a private firm to flag potentially inappropriate Medicare admissions and to establish length of stay criteria. It is used by several hospitals in the Pittsburgh area and by the local professional review organization, KePRO. Questionable admissions, which the case study participants consider rarities, are brought to the attention of the admitting physician by UR staff. If additional information given by the admitting physician is unsatisfactory, a physician from the hospital's UR committee is called in to help resolve the matter. In some hospitals, review protocols vary by class of admission. Depending on pay class and diagnosis, a length-of-stay is assigned. Most hospitals have concurrent reviews for continued stay justification conducted at least every 3 days from the date of admission and may even review patient status daily if continued stay is questionable.

The process is said to run smoothly in hospitals. Overall, the hospitals tend to be quite accommodating of the physicians' admission and discharge practices. One reason behind this may be the relative newness of the state's current PRO. Initially, review responsibilities in the state of Pennsylvania were given to the PRO, PAPRO. PAPRO was reportedly quite disorganized, had difficulty getting data from the fiscal intermediaries, and fell far behind in its reviews. It lost its contract and was not replaced for six months. So, for some time (due to PAPRO's ineffectiveness, and then the loss of the PRO contract) there was no effective PPS regulating body in the state. Few admission denials were forthcoming, so hospitals did not need strong UR programs. KePRO has been in operation for the last 16 months and has reportedly become aggressive in its reviews only recently. The new KePRO aggressiveness might, in future, lead to changes in hospitals' utilization review procedures.

5.3 Use of Hospital Cost and Utilization Data

It is reasonable to assume that utilization review efforts would be helped by providing physicians with feedback concerning the costs and utilization statistics of their patients. Hospitals, however, vary as to the kind and extent of information provided. All site visit hospitals place expected LOS on Medicare patients' charts, while anticipated DRG is most often not available to doctors, mainly because initial DRG classification and final DRG are not always well matched. In none of the hospitals is it reported that any financial information is given to physicians while a patient remains in the hospital.

Most hospitals have instituted some sort of cost and utilization report for physicians. For example, one hospital furnishes quarterly reports to physicians, providing them with their Medicare patients' diagnoses, LOS (comparing it with national average and hospital-wide LOSs), charge and reimbursement data. The Mediscript case severity index is used at some of the hospitals to make this information more accurate.

The extent to which this type of information is used to help form hospital management strategy also varies from hospital to hospital. One hospital has gone as far as producing a "product line" analysis by DRG for hospital department managers. The analysis is retrospective and aggregated over all payers. For patients in all payer categories an expected DRG is compiled and is assigned to a particular department. For each department the product line report contains case frequencies (by payer class), total department expenses and revenues (over all payers), and average LOS for DRG and department.

Winner and loser DRGs, DRGs for which Medicare reimbursement exceeds (or falls short of) the hospital's costs per case, have not motivated any changes in hospital management strategy at any of the hospitals visited. Some hospitals have made no attempt at all to differentiate between winners and losers, while others are aware of winners and losers but only with respect to charges, not costs. Therefore, hospitals' management responses to PPS are not DRG-specific. No attempt to specialize in winner DRGs has occurred.

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

As an urban environment, Pittsburgh has a solid base of services for post-hospital care. There seems to be an adequate supply of both institutional and community-based health care services. The barriers to care relate more to lack of resources for payment than to availability of facilities.

6.1 Discharge Planning

All five hospitals participating in the case study provide discharge planning services for their patients through the Social Service Department. Although Social Service has primary responsibility, three of the hospitals have also established formal Discharge Planning Committees, the membership of which varies among the hospitals but basically includes a social worker, nursing staff, a home care representative, UR coordinator, and medical staff. Generally the committee meets weekly. In the larger hospitals, each floor or service has its own meeting at which all patients are reviewed for post-hospital care needs and to facilitate discharge planning.

Four of the hospitals have open referral systems; any appropriate staff person can informally refer a patient for discharge planning assessment. In the remaining hospital, only the physician can refer a patient; it was noted that discharge planning frequently gets started rather late in this facility. Most of the hospitals are putting new emphasis on getting an early start on discharge planning. In several hospitals, every patient is screened within 24 hours of admission. Three of the discharge planning departments have formal criteria to identify patients at particularly high risk for requiring post-hospital care.

All of the planners indicate that patients are being discharged earlier and require more follow-up care. Most indicate that these patients can be adequately served in other settings. However, one discharge planner expresses concern that readmissions appear to be on the increase among the elderly. She comments that this may indicate that discharges are premature.

Two of the hospitals have active home care departments that provide assistance to social service for referrals. A third hospital has a contract with a nearby home health agency. For the most part, discharge planners take responsibility for arranging post-hospital care. In hospitals without home care departments, they develop the potential alternatives from which the patient, family or physician choose. For nursing home placements, it is more difficult when the patient is likely to seek Medicare payment for care. Discharge planners believe that nursing homes are reluctant to accept these patients, because the Medicare payment rate is so low. One of the hospitals has formal transfer agreements with about forty nursing homes, a number of congregate living facilities and a hospice. Placement of patients is facilitated through this network.

6.2 Home Health Agencies

Six home health agencies were visited, including a Visiting Nurse Association, a small free-standing proprietary, a hospital-based agency, a hospice and two large agencies that are organized to provide care to multiple hospitals. This range of agencies indicates that home health is a rapidly growing health industry in Pittsburgh. Medicare is the primary payer among the six agencies visited, representing from 75 to 85 percent of the agencies' total revenues.

The hospital-based agencies receive most of their referrals from hospitals. One of the community-based agencies receives referrals primarily from non-hospital sources: physicians (30%), skilled nursing facilities (SNFs) (30%) and personal care homes (30%). The other receives a quarter of its referrals from physicians and direct patient referrals, although the remaining 75 percent are from hospitals.

All agency directors are in agreement that patients referred from hospitals are sicker now than they have been in the past. They believe that the newer patients are generally less stable. More patients have serious decubiti, and require more acute care in general. They find that many more post-surgical patients need visits twice daily, IV antibiotics, hyperalimentation, naso-gastro feedings, tracheotomy, or are ventilator dependent. Agency directors feel that more acute care is being provided both to patients who are being discharged from hospitals earlier and to patients who are receiving services as out-patients as an alternative to in-patient care.

These increased demands include longer nursing visits, increased needs for specialty nursing, more medical equipment, and more need for teaching services. To meet the increase in acuity levels and changing needs, some home health agencies are hiring nurses with backgrounds in ICU and acute care, another is seeking nurses with extensive experience in community nursing, another is adding specialty RNs. One agency has developed a number of specialty programs (renal, hospital IV, rehab) providing comprehensive care to individuals. The only difficulty agencies have around staffing is the recruitment of physical therapists; one agency is hiring rehab nurses to provide that care, because physical therapists are simply unavailable.

There is some variation in caseload trends among the agencies. Two report that referrals have stayed about the same. One reports an increase from 1984 to 1985 with a recent drop-off in referrals. Two agencies report growth in referrals. Most agency directors attribute these trends to the aggressively competitive home health market, as well as to PPS. The main sources of referrals are hospitals, and at the inception of PPS, hospitals lined up with agencies to facilitate discharges. For agencies not associated with a single hospital, competition for access to referrals is intense. One frequently used mechanism is the development of a home care office at a hospital, to assist discharge planners in designing post-hospital care plans.

The directors also report that while referrals have grown or stayed the same, the average length of stay or number of visits has decreased. They believe that this is due to a "tightening up" by the fiscal

intermediary. The relationship between agencies and the intermediary appears to be a negative one. Directors complain of inconsistencies in claims review, of arbitrary decisions, of denials without reason, etc. The directors comment that the FI is reluctant to communicate with them. Bulletins are frequently distributed after implementation. Policies are not clearly defined. Frequently the FI refuses to put its decisions in writing. Directors report major concerns that the cost-cutting efforts of the intermediary are resulting in poor service to patients.

6.3 Nursing Home Administrators

Four nursing homes participated in the case study; two are religiously affiliated, one is a public facility, and one is a component in a private health system. Three facilities have a Medicare share of less than 10 percent, while the fourth receives 90 percent of its revenues from Medicare.

These directors indicate that patients are more acutely ill at admission than in the past. There are increases in IV antibiotics, hyperalimentation, post-op patients, patients receiving out-patient chemotherapy and patients dependent on ventilators. One respondent (with a 90 percent Medicare census) notes that patients with diagnoses of fractures and CVAs are requiring increased lengths of stays. She estimates that, on average, CVA patients are being discharged from hospitals a week earlier and fracture patients are being discharged as soon as they are ready for physical therapy. She has also noted an increase in admissions of terminally-ill patients whose lengths of stay are very short. Admissions of this type seems to account for the increase in deaths at the facility. She notes 12 deaths in November, 10 in October, and six in September; although she has no statistics, she believes that this is higher than pre-PPS. A fourth administrator reports that all the severity indicators at his facility show that there has been no changes in the acuity level of patients (the facility has 2.4 percent Medicare days).

Because the four case study facilities receive the main portions of their referrals from very different hospitals, there is variation in terms of opinions regarding discharge planning. The public facility has experienced no increase in referrals from discharge planners, although patients are more acutely ill. The director thinks that the discharge planners are more thorough, initiate planning much earlier, and pay more attention to community alternatives. However, this facility has a standard waiting list of about 40 referrals and a waiting period of about six weeks.

The director of the facility that is a component of a health system is having a different experience with discharge planners. In her opinion, the planners aren't as thorough as they've been in the past; they don't have as much information about the patient and after-care needs. She assists discharge planning at one of the three hospitals in the system by making weekly rounds and meeting with the discharge planners.

The other two facilities are religiously affiliated. One receives referrals primarily from families, and the other has a solid relationship with a single hospital, also religiously affiliated.

To meet new needs, the facilities that are experiencing changes are investing in additional equipment (e.g., IV pumps, feeding pumps, in-wall suctioning), as well as in upgrading and adding staff. One large facility has recently increased its staff by 26 RNs. A smaller facility (less than 100 beds) has increased RN coverage to three RNs per unit during the day shift and 2 RNs per unit on the other two shifts, and added a physical therapist. One facility has developed a extensive in-service training program to teach all staff new techniques for managing the sicker patients.

These two facilities have found that the payment system is not keeping up with this change in acuity level. For example, although patients are receiving chemotherapy treatments on an out-patient basis, the ambulance ride between the facility and hospital is not covered by Medicare. Other examples include strict limits on payment for tube-feeding nutrition and on the number of catheter changes permitted weekly, even though physicians' orders and patient condition require otherwise. One director notes that her facility is permitted payment for tube feeding nutrition elements for 30 days a month. Nutrition costs for the 31st day are denied. Another example cited is the use of the Clinatron beds, a technological advance that is extremely effective in treating decubiti. No payment is available for using the beds as a preventive intervention; the facility must wait until a patient's decubiti are severe enough to need curative care.

Three respondents indicate that there has been a change in the policies of the fiscal intermediary regarding Medicare coverage. One director notes that the definition of skilled care seems to be made almost on a case-by-case basis. She commented that fractures of arm, leg, pelvis, and hip would have been covered last year and now are not. Another administrator comments that each week the FI's guidelines for Medicare become tighter. She reports that Medicare used to cover all gastro-tube care; now extensive documentation is required. The same is true for coverage of oxygen care; now only the initial phase is covered. In rehab, the notes must document daily progress, or services are not covered. At the same time, she indicates that the FI is helpful in working with their utilization review staff and has developed a provider relations office that is responsive to questions and problems.

The nursing home administrators are in agreement that there is no shortage of SNF beds in Pittsburgh. However, they do believe that it is difficult to find placement for patients who are dependent on Medicare. Governmental funding for post-hospital care is a major issue. Some respondents note that patients who are dependent on Medicaid for nursing home care are much more difficult to place than those with private funds. Functional level reportedly is not as much of a barrier as payment source. Respondents from both the home health industry and the nursing home industry express concerns regarding the role of Medicare in

post-hospital care. They believe there is a lack of clarity regarding interpretation of the Medicare benefit structure that causes confusion about coverage among hospitals, physicians, beneficiaries and the post-hospital providers.

7.0 PPS PROGRAM OPERATIONS

7.1 Peer Review Organization

KePRO, the Professional Review Organization for Pittsburgh, is a second generation review organization, assuming responsibilities for review in July 1985. The fact that KePRO replaced a contractor (PAPRO) that failed has strongly influenced the way that the present PRO conducts itself. KePRO believes that its predecessor failed because of its decentralized management which allowed for continuation of regional differences. According to respondents, the predecessor's data system was never completely operational.

The present organization is managed quite differently; the operations have been centralized to facilitate effective decision-making. The new organization was expected to assume the contract and be totally operational within a very limited timeframe. The original contract included the provision that KePRO process the backlog of work left by the first contractor, however that part of the contract apparently was rescinded.

7.1.1 Record Review

All record review by non-physician reviewers is done on site, with the exception of reviews of cost outliers which are done by the area offices. The first level of physician review is also done on site, if possible. The process of review begins with a screening by a KePRO non-physician reviewer. Records not approved are directed to the physician reviewer, who either approves or denies. In the case of denials at this step, additional material is requested and may or may not be forthcoming from the attending physician. Denials are referred to a physician of the appropriate specialty. When the review physician agrees with the admitting physician, no other action is taken. When the review physician does not agree with the attending physician, a letter explaining the decision is sent to the latter. A request for reconsideration must be made in writing to the PRO within 60 days.

The staff reviewers are AARTs, ARTs, LPNs or RNs, although the mix favors RNs. Some reviewers have PSRO experience; some have only hospital training. At start-up, there was a two week training program for reviewers. Now, new employees are trained on-the-job and are able to work independently in about a month. The PRO has had more staff turnover in the Philadelphia area than in Pittsburgh. There is no system in place to measure the productivity of reviewers, although there has been some initial work to put one in place.

The experience with physician reviewers has been positive overall. Most physicians are not reluctant to participate, probably because the Medical Association is the PRO's sponsor. However, there have been shortages of reviewers in cardiology, orthopedics, oncology, neurology and gastroenterology (in some areas). The complaint that the PRO "doesn't pay enough" has been an isolated response. Although there has been physician participation, the majority of physicians "do not

participate fully" because they think that the PRO will go away, following the same path as the PSRO. In Pennsylvania, the number of PSROs declined from 12 to 5, and many areas were without PSRO review for some time.

Physicians complain about retrospective review. PRO staff confirm the description heard elsewhere concerning the conservative style of medical practice in Pittsburgh, admission rates are high, lengths of stay are long, while the incidence of malpractice is low.

7.1.2 Types of Review

KePRO has a somewhat unique experience because it assumed operations out of time sequence with the remaining PROs. Consequently, it has proved to be an opportunity to serve as a model for proposed changes in the review process. For example, KePRO in its original contract included 22 generic screens many of which have now been adopted for all PROs. Examples, of these generic screens include:

1. Unplanned return to the operating room;
2. Delay in administration of a treatment;
3. Unplanned organ removal;
4. Admission necessitated by an outpatient procedure.

Cases that fail one of the generic screens are assigned a severity score ranking from one to seven by a physician reviewer. Cases with a score of four or higher are referred to the Quality Assurance Committee. The process may result in a corrective action, sanction, or initiation of focussed review of the provider's claims.

The generic screens, developed by KePRO staff as promised in their proposal, were completed prior to HCFA's development of a set of generic screens. The PRO may have to adopt HCFA's generic screens which are similar but not as rigorous in some cases as KePRO's.

The PRO's review policy includes no provision to review outpatient claims. KePRO is the only PRO doing prospective review of transfers. The prospective review may be changed under the new regulations, but it has served primarily to catch premature transfers. The receiving institution appreciates the process because they don't admit patients "dumped" before they are ready to be released. The prospective review must be balanced with retrospective review. Failing the prospective review need not mean outright denial. The request may be withdrawn or the hospital can go ahead and transfer taking the risk that they may not be paid based on a retrospective review.

In other cases, the PRO has flagged possible problem areas to be investigated. They proposed to HCFA a 100 percent review of all cases in DRG 461, post-operative complications. The PRO has also proposed to review outpatient cataract and hernia procedures that should have been done as inpatient procedures.

7.1.3 Objectives

KePRO inherited its predecessor's objectives which they were to validate within 9 months or propose new objectives. At the time of the interview, the objectives had not been changed in their contract although suggestions were submitted 8 months prior. The PRO suggested dropping mastectomy reviews and adding cholecystectomy reviews. The PRO is not meeting its objective related to pacemaker admissions.

The review by the the Super PRO has been satisfactory (KePRO was rated at the national average in year one), although most of their problems are that the Super PRO has a "California mentality" and is looking for higher denial rates than the PROs. For example, KePRO has been cited for excessive rates of cardiac catheterizations. However, in Pennsylvania, catheterizations are not done on an outpatient basis at all. The Super PRO review process presents problems to the PRO because it places undue time pressures on KePRO to respond. The KePRO has only 15 days to respond to a Super PRO concern. The Regional Office could effectively perform the review function, in their view.

7.1.4 Denials

The PRO believes that high denial rates mean that there is a need for a change in provider behavior. The incidence of high denial rates says a lot about the conflict between the financial constraints of the reimbursement system and physician preference. According to the medical director, a physician believes that high quality care is doing what he/she wants. The PRO concept is one that defines quality care as that care that is medically necessary. This reportedly sounds like rationing to the physician community. High denial rates also suggest that the PRO is not adequately performing its educational functions.

Emergency medical admissions yield the most frequent denials. Denials may trigger intensified review (i.e., review of all of the providers' claims). Presently, there are 64 hospitals on intensified review, 5 for intensified DRG review and 6 for cost outliers. The implementation of new criteria has increased denials threefold from around one percent in the first 12 months to nearly four percent since July 1986. Providers initially were not upset by denials as long as they were just letters from the PRO. When the fiscal intermediary took back the payment for denials, the hospitals reportedly took notice.

The PRO has not reported a "dumping" of patients as evident by high rate of readmissions. Although the patients are discharged sooner now, there has not been much disagreement concerning the patients' readiness for discharge. No hospital has been reported as saying "your DRG is up."

7.2 Fiscal Intermediary

The fiscal intermediary (FI) for the Pittsburgh site is Blue Cross/Blue Shield of Western Pennsylvania (BC/BS WP). The present organization represents the consolidation of independent BC/BS plans at four sites under BC/BS WP. BC/BS WP is the second largest intermediary

in the country, and they place themselves among the most efficient FIs, evidenced by an average processing cost of $3.49 per claim; and they believe that the consolidation may realize additional efficiencies in the future.

7.2.1 Relations with HCFA

The FI reportedly experiences difficulties as a result of HCFA's policies towards intermediaries. First, the overall budget cuts that have been applied uniformly to all contractors discriminate against efficient contractors, like BC/BS WP, who have little or no excess cost to cut. The second issue is one that has received a considerable amount of attention from providers, the Congress, and from the media, namely the directive to intermediaries to withhold payment to providers until the twenty-eighth day. HCFA's interpretation that Congress's directive means to pay claims on the twenty-eight day has provoked strong reactions from providers and the FI must deal with these directly.

Generally, the respondent believes that the Medicare program has "lost much of its integrity," due largely to the steady stream of system changes that have been imposed. Many of the legislated changes require a major overhaul in the intermediary's functions. Other changes originating in HCFA Central Office are ill-timed. The FI believes that the bureaucratic initiatives should be held until the present situation stabilizes. Tinkering with the system may introduce serious strains on providers who then pressure the FI. It is the pressure to respond to the concerns of providers coupled with the increased demands from Baltimore that is reportedly draining the FI's resources.

7.2.2 The Intermediary's Performance

The FI respondent states that CPEP, which serves as a yardstick to evaluate FI performance, is inadequate. Measuring output per day is a poor indication of performance generally, and this is particularly true during periods of rapid change. Because CPEP measures performance at only one point in time annually, its sample is too small to be representative. The respondent proposes monthly or quarterly reviews. The FI has had some recent problems with CPEP. It failed the performance standard for medical review reportedly because the review was done at the individual BC/BS plans. Consolidating the function has resulted in an improved score.

The FI is appealing its recent poor overpayment score, which was a result of the failure of their reporting system to catch up with the actual collections. Until last year, the record has been "perfect" and the staff does not feel that they failed in any critical elements.

The activity of HCFA's Regional Office is viewed as helpful, although when the central office gets involved the timing of responses to questions becomes "unreasonably slow." For example, the problems with implementing the 485 for home health care could have been minimized with better communication between central office and the FI. The 485 has generated many problems and has proven to be a significant drain on the FI's resources.

7.2.3 Claims Processing

Claims are received and edited in three processing sites, located in Wilkes-Barre, Harrisburg and Pittsburgh. The majority (89 percent) of claims are machine readable, while the home health and hospice claims are all paper claims. The editing procedure for claims varies depending on the way that the claim is received. For claims entered by CRT at the provider, there are consistency edits on-site. For claims received on tape, there are initial edits that may be corrected on the tape; if the correction is not possible, the claims are returned to the provider. The paper claims are sent to the local plans where they are sorted, keypunched and then entered into the system.

There have been recent changes in processing so that only hospital claims will be received in Harrisburg, while Wilkes-Barre and Pittsburgh will continue to receive all types of claims. All keypunching will be done at the Pittsburgh site to promote efficiency in processing paper claims. Another recently implemented change directs all claims from the three sites to a single processing facility located in Lemoyne, where the PRO is also located.

For inpatient, outpatient and home health claims, the initial step in the processing of claims is an inquiry as to beneficiary eligibility. Claims may be rejected due to the presence of a secondary payer or because the claim is sent out for medical review. The claim, after satisfying the medical review and secondary payer, will then be paid on demand. Claims accumulated Friday through Thursday are paid on the following Tuesday.

The FI reports the following statistics showing the processing speed for October 1986 as a typical month:

1. Inpatient Claims. Approximately 78 percent of inpatient claims were paid in 27 days; 93 percent were paid in 28 to 60 days; and 95 percent were paid in 61 to 90 days.

2. Outpatient Claims (n=172,000). Nearly all (95 percent) were paid within 27 days.

3. SNF Claims (n=3,600). Forty seven percent were paid within 27 days; 50.7 percent were paid in 28 to 60 days; 94 percent were paid in 61 to 90 days; leaving 6 percent unpaid after 90 days.

4. Home Health Claims (n=900). Eighty-three percent were paid within 27 days.

The FI keeps no record of the number of claims returned to providers because of failed edits, but it is reportedly paper claims, primarily for home health and SNF services, that are the most problematic. To solve the problem, the FI has tried to educate providers with limited success. Currently, the FI is pursuing the marketing of an

alternative means for these providers to submit claims. A subsidiary of BC/BS WP has developed software for personal computers that would allow SNFs to submit claims in a machine readable format. About 30 SNFs have already purchased the system. Other applications (i.e., for home health claims) are under development. Applying the above software system to HHA claims may be problematic because medical information justifying the need for services is required on every claim.

7.2.4 Home Health Agencies

The review of home health agency (HHA) claims has proved more demanding of resources with the adoption of the 485 form; at the same time the number of claims has increased by 50 to 60 percent in the past 2 or 3 years. The FI now requires two permanent reviewers for HHA claims and also employs ten temporary reviewers to handle the increased volume. These staffing changes are noted by at least one HHA which cited the inexperience of claims reviewers and lack of continuity in reviewers as problems.

The definition of homebound has not changed but the FI reports that problems in getting correct and complete documentation from several HHAs have resulted in more frequent investigation and denial activity. The FI observed that some denials may be a result of a conflict between the HHA philosophy which may include social and economic considerations while Medicare only considers clinical factors.

The FI and home health industry representatives recently produced a new definition for homebound status. Aetna, the regional FI, and BC/BS WP are participants in this joint effort. The definition was also reviewed by PAHAW, a statewide organization of HHAs. Similar efforts to define skilled care, intermittent care and daily care are also planned.

7.2.5 Skilled Nursing Facilities (SNFs)

The principal difficulty in screening SNF claims is that definitions of level of care are not clear to owners. There is a need for professional UR caseworkers to determine services based on "need," not on availability. Since the inception of PPS, there has not been a substantial increase in the numbers of SNF claims, probably because the supply of SNF beds has served to constrain this type of care.

The intermediary's review process varies somewhat depending on the type of claim. For SNFs, reviews are conducted on 100 percent of claims, bills are submitted every 15 or 30 days with the required clinical information. For HHA claims, the 485 form (clinical detail) is required on the initial claim. The FI reviews 100 percent of these claims and of all interim claims prior to recertification. The FI places no emphasis on retrospective review for the HHA claims. For outpatient claims, there are some mechanical (based on diagnosis) screens and some manual screens.

Other automated screens will be added to the system as they are made available. For example, the FI (along with all contractors) will be installing software from HCFA for physical therapy claims review in April 1987. At this time, screens are applied to a 1-2 percent sample of machine readable claims.

Reviewers are all registered nurses, with some background in the area they review. Since RNs cannot deny a claim, a physician reviewer serves as a back-up to the RN reviewers. If a physician needs a specialty consult, the FI contracts for the needed services. No effort is made at this time to track the productivity of reviewers, although some method will be installed in the near future.

The FI reports that denials are typically focussed on a few providers. A few SNFs, typically small ones, continue to have higher than average denial rates. The FI reports that of 22,770 SNF claims between October 1, 1985 and September 30, 1986, there were 1.51 percent denials. For HHA claims, there was a 0.75 percent denial rate in September, 1985, which increased to four percent in September, 1986. This increase in HHA denials is the result of the intensity of review made possible using the information required on the 485 form. It is expected that the denial rate will fall to about two percent and remain there.

During the quarter July through September 1986, the FI realized $663,000 in savings to the Medicare program due to denial activity. The bulk of the savings (45 percent) was realized from SNF claims. The majority of providers are on a waiver of liability. There has been a small amount of attrition since PPS, but generally the number of waiver facilities has remained unchanged.

The FI sometimes has the unpleasant duty of relaying HCFA's policy changes to the provider community. As with the policy to withhold payment until the twenty-eighth day, the FI typically notifies the providers by mail. There were some workshops held early in the PPS transition to explain the system to providers. The loss of periodic interim payments (PIP) will be felt by a large number of providers (100 or so, mostly hospitals), and a few may suffer serious cash flow problems.

However, generally speaking, the perception is that most hospitals are making money. The prevailing practice style has provided a very soft cushion for most providers. There has been no evidence from either the FI or PRO of early discharge. Moreover, the indirect medical education payment has provided an extraordinary bonus to many hospitals. There is some evidence that HHA patients are more severely ill, a factor which may ultimately lead to more intensive services and more HHA denials. To date, little effort has been exerted by the FI or the hospitals to influence physician behavior.

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